

Authorization

I, the undersigned, _____ ,
covered under Insurance Policy No. _____ , authorize Nouveau-Brunswick Medicare to release to Humania Assurance
situated at 1555, Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6 (to the attention of the Claims Department), the names of the
health professionals who rendered to me services paid for by the Régie, the amounts the Régie paid them for the services and the
dates on which the services were rendered for the period from _____ to the present day

I declare that I am aware of the purpose for which this information will be used by the above-named person, and therefore give my informed
consent to its disclosure.

This authorization is valid for: an unlimited time

A duplicate signature will not be accepted.

Number of your NBM card: Date of birth:
year / month / day

Signature: _____ Date:
year / month / day

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6